

**Appendix 1** to Dean P, O'Donnell M, Zhou L, et al. Improving value and access to specialty medical care for families: a pediatric surgery telehealth program. *Can J Surg* 2019.

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## **Appendix 1. Patient questionnaire**



### How did we do?

We'd like to know what you think about your visit today. Please help us by filling out this short survey. It should take less than 5 minutes to complete.

This survey is made up of two parts. Parents should complete part 1. Children are welcome to complete Part 2 by themselves or parents can help their child complete Part 2 as required.

After completing the survey, please return it to the person who showed you to your telehealth room.

Part 1: To be completed by parent	
Question	Response
1. Which age group best describes your child's age?	<input type="checkbox"/> Less than 1 year <input type="checkbox"/> 1 to 4 years, 11 months <input type="checkbox"/> 5 to 11 years, 11 months <input type="checkbox"/> Over 12 years
2. What is your postal code?	____ ____ (Postal Code)
3. This was my child's first telehealth visit experience.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. It was easier for my family to travel to the telehealth appointment instead of travelling to BC Children's Hospital.	<input type="checkbox"/> Much easier than traveling <input type="checkbox"/> Somewhat easier than traveling <input type="checkbox"/> About the same as traveling <input type="checkbox"/> Not much easier than traveling <input type="checkbox"/> More difficult than traveling
5. If we had travelled to see the health care provider(s) we saw today <i>in-person</i> we would have had to travel ____ <i>more</i> time in each direction.	<input type="checkbox"/> ____ hours and ____ minutes (ESTIMATE 1 DIRECTION ONLY)
6. If we had travelled to see the health care provider(s) we saw today <i>in-person</i> instead of having a telehealth visit, I (parent) would have missed ____ <i>more</i> hours of work.	<input type="checkbox"/> Parent 1: ____ (hours) <input type="checkbox"/> Parent 2: ____ (hours) (if applicable) (COMPLETE/SELECT ALL THAT APPLY)
7. If we had travelled to see the health care provider(s) we saw today <i>in-person</i> instead of having a telehealth visit my child would have missed ____ <i>more</i> hours of school.	<input type="checkbox"/> ____ hours
8. If it was available, we would use telehealth again to see the doctor/nurse.	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Maybe <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree <input type="checkbox"/> Don't Know

Completing the survey is **voluntary**. All your information will be treated **confidentially**, in compliance with the BC Freedom of Information and Protection of Privacy Act. The information collected through this survey is solely for the purpose of program evaluation. Individual answers will only be shared with those who collect and send this survey to those who summarize the answers to all surveys. Your name nor the name of the person that you accompanied to this visit will not be recorded.



**Part 2. To be completed by the child, with assistance from an adult, or by the parent for young children**

Question	Response
9. I was at this telehealth visit on my own (without a parent or adult caregiver)	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Please tick the response below that most closely matches your experience during this telehealth visit.**

During my telehealth visit:	All of the time	Most of the time	Some of the time	Not a lot of the time	I am not sure
10. I could see the doctor/nurse clearly.					
11. I could hear the doctor/nurse clearly					
12. I thought that the doctor/nurse could see me [and my family].					
13. I thought that the doctor/nurse could hear me [and my family].					
14. I felt comfortable in the room where the telehealth visit was held.					

**Our visit took place at (Hospital/Location Name):** \_\_\_\_\_

**The type of visit was:**

- Preoperative Visit with Surgeon
- Preoperative Visit with Anaesthesiologist
- Post Operative Follow-up Visit with Surgeon
- Metabolic or Biochemical Diseases
- Neurology Visit
- Endocrine/Diabetes Visit
- Cardiology Visit
- Gastro-intestinal Visit
- Other: \_\_\_\_\_

**The date of our visit was:** \_\_\_\_\_

**Please give this completed survey to the person who showed you to the telehealth room.**

**For administrative use only: Please refer to the TEACC Telehealth Protocol for directions on receipt of completed surveys.**

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